

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 09-29-03.

The IRO reviewed office visits, special reports, myofascial release, ultrasound therapy, therapeutic exercises, hot or cold pack therapy, therapeutic procedures, psychiatric diagnostic interview, functional capacity exam, work related medical disability exam rendered from 10-17-02 through 01-17-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-14-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

<b>DOS</b>	<b>CPT CODE</b>	<b>Billed</b>	<b>Paid</b>	<b>EOB Denial Code</b>	<b>MAR\$</b>	<b>Reference</b>	<b>Rationale</b>
12-31-02	99212	\$35.00	\$0.00	No EOB	\$32.00	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of \$32.00
12-31-02	99080-73	\$20.00	\$0.00	No EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor submitted relevant information to support delivery of service. Reimbursement recommended in amount of \$20.00
TOTAL		\$55.00	\$0.00				The requestor is entitled to reimbursement in the amount of \$52.00

This Decision is hereby issued this 26th day of March 2004.

Debra L. Hewitt  
Medical Dispute Resolution Officer  
Medical Review Division

DLH/dlh

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 10-17-02 through 01-17-03 in this dispute.

This Order is hereby issued this 26th day of March 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/dlh

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 3/24/04**

MDR Tracking Number: M5-04-0278-01

November 11, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

Sincerely,

### CLINICAL HISTORY

\_\_\_ was jogging \_\_\_ and fell and heard a loud pop in her left knee. Onset of pain was immediate. MRI on 8/21/02 revealed a torn meniscus in the left knee along with chondromalacia patella. Surgery to repair the meniscus was performed 10/2/02 and rehab therapy followed.

### REQUESTED SERVICE(S)

Office visits, special reports, myofascial release, therapeutic procedures, application modalities (hot/cold packs), psych interview, functional capacity exam, therapeutic exercises, ultrasound therapy and work related medical disability exam for dates of service 10/17/02 through 1/17/03.

### DECISION

Treatment was warranted and medically warranted.

### RATIONALE/BASIS FOR DECISION

Due to a surgical repair of the left knee, \_\_\_ required post-surgical rehabilitation in order to return to her field of employment. It is important to note that her job description in law enforcement was one of a high activity level and physical stress. As such, the rehab process needed to condition her knee to a level that would be satisfactory to return to this environment. Based on the records provided, the rehab program was designed with these needs in mind and was in accordance with standard rehab procedures. The performance evaluations and exams must be performed in a case such as this in order to have an assessment of where the patient's recovery is and to modify the rehab program accordingly. Both of these duties were performed and are medically sound treatment plans.

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 24<sup>th</sup> day of March 2004.